Disturbed Behaviour Management - Clinical Practice Standard

1. Purpose

The purpose of this policy is to establish minimum practice standards for disturbed behaviour management throughout the WA Country Health Service (WACHS).

Removing unwanted variation in clinical practice and following best practice guidelines has been found to reduce inappropriate care (overuse, misuse and underuse) thus improving health outcomes, reducing preventable harm and decreasing wastage.

This policy is to be used in conjunction with

- Cognitive Impairment Clinical Practice Standard
- Restraint and Seclusion Minimisation Clinical Practice Standard
- Alcohol, Tobacco and Other Drugs Clinical Practice Standard
- Clinical Escalation of Acute Physiological Deterioration including Medical Emergency Response Policy

Further information relating to specialty areas including Child and Adolescent Health Service (CAHS), Women and Newborn Health Services (WHNS) can be found via HealthPoint if not covered in this policy.

2. Scope

All medical, nursing, midwifery and allied health staff employed within the WACHS.

All health care professionals are to work within their scope of practice appropriate to their level of training and responsibility.

Further information may be found via HealthPoint or the Australian Health Practitioner Regulation Agency.

3. Considerations

- Patient identification and procedure matching processes are to be undertaken where appropriate
- Patient privacy and dignity to be maintained
- The presence of a chaperone to be offered where appropriate to patient and clinician requirements.
- The opportunity for an accredited interpreter and/ or Aboriginal Liaison Officer to be provided where appropriate to the patient's language or communication requirements (refer to WA Health Language Services Policy).

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4. General Information

All patients have the potential to display disruptive, violent or aggressive behaviour within the hospital environment. Aggression can present as a mixture of physical and/or verbal displays that can be portrayed actively and/or passively by the aggressor and may be indirect or directed at the receiving person.

Certain conditions can alter a patient's "normal" pattern of perception and behaviour such as acquired brain injury (ABI) and will require different levels of care as part of their usual routine. "A cross-sectional study suggested that cognitive impairment severity is the most significant predisposing factor for aggressive behaviour among older adults in long-term care facilities".[2] Refer to WACHS Cognitive Impairment Clinical Practice Standard for further information.

Other factors than can alter perception include the presence of medications/drugs or alcohol, exposure to unfamiliar or threatening environments, or underlying medical condition (organic and/or psychiatric). This CPS will address these factors.

5. Warning Signs of Potential Behavioural Change

In order to prevent or reduce the risk of exposure to violence and to assist patients with maintaining personal dignity, reputation and composure, early recognition of warning signs is paramount. These may include:

- tense and angry facial expression
- increased respiration rate, sweating, clenching jaw, hands, facial and body muscles
- increased or prolonged restlessness, body tension ,pacing
- general over arousal of body systems, (increased respiratory rate, heart rate, dilated pupils)
- increased volume of speech, erratic movements
- prolonged eye contact
- discontentment, refusal to communicate, withdrawal, fear, irritation
- unclear thought processes, poor concentration
- delusions or hallucinations with violent content
- verbal threats and gestures
- replicating behaviors expressed during previous episodes
- reporting anger or violent feelings
- blocking escape route.

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6. Risk Assessment Strategies

The potential for aggressive behaviour should be assessed on/at admission/triage. Adequate history taking needs to be conducted to mitigate potential issues arising from behavioural disturbances.

Demographic or personal history	Rationale
• History of disturbed/ violent behaviour. • History of misuse of substances or alcohol. • Reports from carers of previous anger or violent feelings. • Previous expression of intent to harm others. • Transient life style. • Difficulty in communication.	History of aggressiveness is one of the strongest predictors of future aggressive behaviour. Engagement with the patient, relative and/or carer from the onset may enhance the therapeutic relationship, reduce the likelihood of risk and promote patient centred care. Inability to communicate may lead to frustration and aggression. Establish communication plan with assistance from family/care giver e.g. use of sign or key words.
• Previous use of weapons. • Previous dangerous impulsive acts. • Severity of previous acts. • Evidence of recent stress. • Known personal triggers. • Verbal threats of violence. • Reports of anger/ violent feelings.	Clinical risk is identified and responded to through behavioural, verbal or physical ppresentation. Collaborative information and other indicators of clinical risk are sought through sensitive enquiry and questioning.
Clinical Variables (recent)	**Rational**
• Misuse of substances. • Effects of drugs (dis-inhibition, agitation or extrapyramidal side effects). • Active symptoms of mental illness or organic causes.	Agitation, restlessness, coarse tremor and elevated blood pressure and pulse may be early signs of alcohol or benzodiazepine withdrawal. Refer to WACHS Alcohol, Tobacco and Other Drugs Clinical Practice Standard. Aggressive behaviour can be a defence response brought on by psychosis and abnormal thought.
Situational Variables	**Rational**
• Extent of social support. • Immediate availability of a potential weapon. • Relationship to potential victim. • Access to potential victim. • Staff awareness and attitudes. • Limit setting.	Risk assessment includes evaluating the safety of family and staff. NB: Hospitals and community settings have many environmental factors that can isolate staff thereby making them potential victim. Be aware of avenues for escape and the natural use of barriers

The potential for patient's behavioural changes should be discussed with the team providing care and a plan formulated to manage disturbed behaviour. Where a risk of aggressive behaviour is identified this must be communicated to all staff at each hand-over. The ward/area co-ordinator will ensure that all staff involved with the patient care is aware of the potential risks.

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7. Drug Induced Disturbed Behaviour

Many medications, both prescribed and illicit can induce a state of psychosis. Underlying medical or psychiatric conditions can be exacerbated by these medications. Although any drug that crosses the blood-brain barrier has the potential for causing psychotropic side effects, certain commonly prescribed classes of drugs, such as anticholinergics, psychotropics, antihistamines, and many over-the-counter medications, are well documented as causing such side effects.

Medication used for the treatment of persistent pain has the potential to cause abnormal behaviour. Community follow up (for those with persistent pain) needs to be in place. Early recognition of behavioural change is paramount.

Symptoms may include:

- confused thinking
- false beliefs
- hallucination
- changed feelings
- changed behaviour.

For further advice regarding pharmacological management refer to the following WACHS documents:

- Cognitive Impairment Clinical Practice Standard.
- Restraint and Seclusion Minimisation Clinical Practice Standard.
- Alcohol, Tobacco and Other Drugs Clinical Practice Standard.
- Procedural Sedation – Emergency Department Clinical Practice Standard.
- Medication Administration Policy.

8. Emergency Department

Refer to the:

- WACHS Triage, Assessment and Management in the Emergency Department – Clinical Practice Standard.
- WACHS Mental Health Care in Emergency Departments and General Wards Policy.

In the Emergency Department disruptive or violent behaviour is most commonly seen in patients who are intoxicated but not formally psychiatrically disturbed. It is useful to think about these situations as graded emergencies, in which the degree of danger ranges from minimal to extreme and the management strategies vary accordingly.[3]

Common causes of disturbed behaviour experienced in the emergency department can be divided in to: Primary organic and primary psychiatric.[3]

Organic

- Intoxication with, or withdrawal from, alcohol and/or other drugs
- Acute brain syndrome
- Hypoglycaemia
- Dementia

Psychiatric

- Personality disorders, under stress and/or intoxication with alcohol or drugs
- Agitated depression
- Hypomania/Mania
- Emotional situational crisis state
- Schizophrenia

Although hospitals are not required to admit everyone who seeks admission, the hospital with an emergency care facility is obliged to provide appropriate assessment and management in the emergency situation. Emergencies have been legally defined as "injuries or illnesses that could result in death or permanent bodily impairment, and include acute psychotic and suicidal states".

In the first instance, either the primary nurse or doctor who is dealing with the patient should request his or her cooperation and suggest moving to a designated area of the emergency department. Whilst doing this, known data about the patient should be mustered. Many patients will agree to cooperate in formal assessment but if the patient does refuse to cooperate, then an assessment should be made as to their level of risk and their need to remain in the emergency department.

9. General Wards

Refer to: WACHS Mental Health Care in Emergency Departments and General Wards Policy

On admission to the general ward a full history is taken, this should include a violence risk assessment if there is a history or likelihood of behavioural change.

Consideration should be given to the placement of the patient within the ward, to reduce the risk to all caregivers and to protect the safety of other patients.

10. Care of the Older Person

Refer to: WACHS Cognitive Impairment Clinical Practice Standard for advice regarding management and consider the Management of Agitation in Older Adults with Dementia or Delirium flowchart (Appendix 24.5 in the above CPS).

If a patient is identified as having challenging behaviours or behaviours requiring ongoing management and assessment, the care plan should be reviewed as determined by clinical condition or senior clinical assessment to ensure that the strategies used to manage behaviours are effective (refer to: WACHS Residential Aged Care Services Policy).

Once organic causes for disturbed behaviour have been eliminated, management plans can be created. These may include medication regimes introduction of activity meaningful to the patient and action plans for de-escalation and failed de-escalation. Staff should follow Section 13 - recognised De-escalation Techniques.

11. Mental Health

Refer to the:

- *Mental Health Act 2014* (WA) and Mental Health Regulations 2015.
- Policy for Reporting of Notifiable Incidents to the Chief Psychiatrist - Public Mental Health Services 2018 (The MHA 2014 s254, 1 (a-c) and s525 (a-e) outline the types of incidents that must be reported to the Chief Psychiatrist. Notifiable incidents must be reported to the Chief Psychiatrist as soon as practicable, ideally within 48 hours of the event)
- WA Chief Psychiatrist's Standards for Clinical Care 2015
- Charter of Mental Health Care Principles
- WA Health Clinical Care of People with Mental Health Problems who may be at Risk of Becoming Violent or Aggressive Policy (and supporting information).
- Clinical Risk Assessment and Management (CRAM) in Western Australian Mental Health Services: Policy and Standards.
- WACHS Mental Health Care in Emergency Departments and General Wards Policy.
- WACHS Restraint Minimisation Policy, WACHS Mental Health Seclusion Policy and WACHS Mental Health Restraint Policy.

On admission to the ward/area a formal risk assessment should take place, refer to: Section 6: Risk assessment strategies. A structured sensitive interview with the consumer, and where appropriate their carer, is an important assessment tool with the potential to de-escalate situations which may become violent.

The aim of the interview should be to elicit the consumer's view regarding their triggers, early warning signs and possible management strategies that have worked previously. Strategies to reduce the risk of disturbed behavior need to be in place, this can include environmental designs including rooms and designated areas which reduce arousal; areas which encourage physical recreation, the opportunity to engage in appropriate activity and access to fresh air.[4]

12. Clinical Communication

Clinical Handover

When patients, who have a history of aggression, are transferred to/from another health care facility/wards, this must be communicated both verbally and in the transfer form/health care record. Information exchange is to adhere to the Department of Health Clinical Handover Policy using the iSoBAR framework.

Critical Information

Critical information, concerns or risks about a consumer are communicated in a timely manner to clinicians who can make decisions about the care.

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Documentation

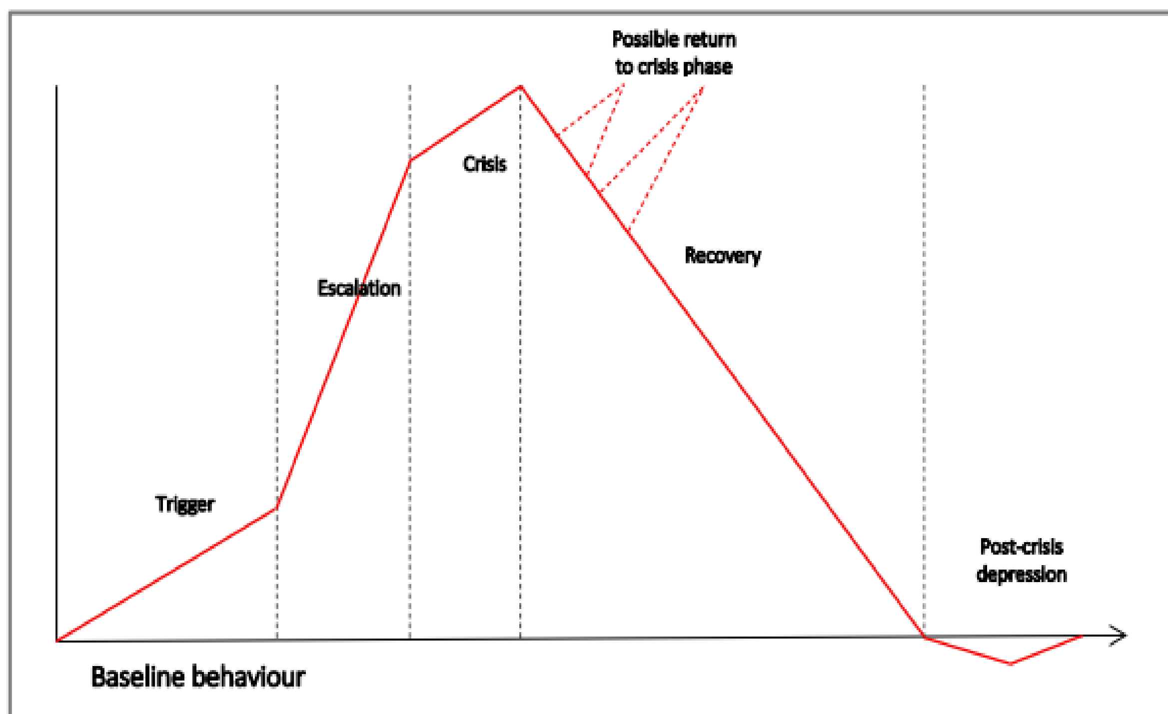
All de-escalation, physical restraint or seclusion interventions are to be documented in the patient's health record with appropriate consent, intervention plans, medical review and evaluation of intervention effectiveness.

Documentation and mandatory reporting of seclusion and restraint interventions within an authorised place must be in accordance with the *Mental Health Act 2014.*

Refer to the WACHS Documentation Clinical Practice Standard.

13. De-escalation Techniques

De-escalation is the process of recognising early signs of distress, anger or frustration and intervening to reduce the level or intensity of those feelings before the behaviour becomes assaultive or destructive. It is important for staff to recognise and attempt to understand what is triggering a person's violent, aggressive behavior, and also recognise where along the aggression cycle (see Figure 1) the person has reached in order to intervene appropriately.



(Figure 1: The Assault Cycle[5])

Non Verbal Communication Skills

Acronym: PERFECT	Potential Intervention
Proxemics (stance/ posture/ space): angry aroused people have an increased need for personal space	Respect the need for increased distance and space between the aggressor and yourself. Adopt a non-confrontational posture and stance – place them at a 45^0 angle. Do not stand directly in front of the angry person

Non Verbal Communication Skills continued

Acronym: PERFECT	Potential Intervention
Eye contact: prolonged eye contact with an aroused person can be misconstrued as being provocative and no eye contact may be thought of as submissive/ fearful	Attempt to mirror the contact that happens in normal conversation. Avoid prolonged eye contact
Respect touch boundaries: the use of touch with someone who is highly aroused requires extreme care. Touch should only be performed with permission and performed in a manner that represents respect and dignity.	Touch should either be avoided altogether or used very slowly so that the aggressors' actions can be observed
Facial expression: serves to convey and reinforce the content of speech.	Ideally ones facial expression should remain neutral but interested
Environment: the environment has both physical and social dimensions. If a number of people are around during the incident and this is causing a negative effect (e.g. making negotiation/ communication more difficult), the situation should be altered.	The influence of the group needs to be monitored continuously. Replace personnel as appropriate as different staff may relate to the aggressor more effectively. Alter environment as feasible and appropriate.
Consider the influence of your appearance: clothing and appearance can convey very different messages. Uniforms can standardise appearances but may also be viewed as a barrier of authority	Consider the number of people in the environment and their clothing. If perception is that uniforms are acting as a barrier of authority, reduce this number if safe/feasible or reduce uniform numbers – change or add to clothing
Think about your hand movements: try to show interest and concern in your posture but not aggression or submission	Hold hands with palms open in view of the aggressor demonstrating minimal threat. Do not place hands on hips or in pockets, fold your arms or place your hands behind your back.

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Verbal Communication Skills

Acronym: LOADS	Potential Intervention
Learn to actively manage the pitch tone and volume of your voice: aim to convey an empathetic response and avoid escalating the situation further	Adopt a calm approach. Speak in a normal conversational pitch tone and volume. If a calm response is having little effect try to raise the volume and pitch to enhance communication – once it is achieved (even briefly) revert back to a normal volume and tone. Controlling your breathing will assist you to monitor your pitch tone and volume.
Overload with agreement: agreeing with everything an extremely angry person says can often avoid giving the person an opportunity or reason to move from being verbally abusive to physically violent. Partial agreements can acknowledge some of the aggressors' statement. By asking for his/her input into the situation/ solution, it can disrupt the aggressors' personal attack and opens the way to establish an alliance.	When service users are extremely distressed and angry, staff to consider what they agree with. This may include using the word 'sorry' to show empathy e.g. "I'm really sorry that you feel we are not interested in what happens to you". Where anger is less extreme consider making partial agreements and include a statement that involves the aggressor to stop and think e.g. "I can hear that you are upset, what has made you feel that way?"
Acknowledge and check feelings: acknowledgement of feelings is an important dimension of practice	Note tensed muscles, position/ stance of person to see if your words/ actions are having an impact on de-escalating the situation and amend actions accordingly
Distraction: some triggers of aggression may be in our control and the resolutions simple. However, some things are not within our direct control and we must be seen to be progressing to attempt to reduce the trigger	Identify the source of the anger and remove it if possible. Remind the person of the relationship you have with them e.g. you are the Nurse; the Doctor is the one who you need to speak to regarding medications. Take care not to redirect anger back to the aggressor. Temporarily distract the aggressor e.g. offer to make a phone call on their behalf to someone, offer fluids and/or diet

Verbal Communication Skills continued

Acronym: LOADS	Potential Intervention
Start to negotiate: negotiation means entering into a discussion between people who have different aims or intentions, where they try to reach an agreement. It is important not to provoke the situation and to speak in a language that is appropriate for all people involved and in the context of the situation	Establish an agreement to negotiate. Ascertain and clarify things that are not negotiable. Establish ground rules e.g. no shouting, swearing

Established Communication Skills

Acronym: LASSIE	Potential Intervention
Listen and hear: listening to an angry client may present ideas of what options you may be able to offer	Use open ended questions, ascertain the trigger/s and paraphrase to reinforce you have heard and clarify your understanding.
Acknowledge: acknowledge their feelings and begin to introduce boundaries such as appropriate/ inappropriate behaviours	Reaffirm you understand why the feelings / anger is there. Set limits and boundaries - setting limits is not about telling someone what to do; it is acknowledging the consumer may not be able to see the consequences of their behaviour and assisting them to find an appropriate way of behaving.
Separate: find a place whereby you will not be disturbed and continue to progress with communications	Remove the person from a hectic environment if appropriate. Inform colleagues of your location and approximate time you may need – Do NOT isolate yourself
Sit down: identify you have acknowledged the real situation using clarification and talking about the same thing	Sit down and try to expand on what you have heard in the listening phase.
Indicate: provide options as appropriate	Options must be realistic and achievable
Encourage: encourage the person to choose from one of the options available	Commit yourself to the option chosen

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14. Compliance Monitoring

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

15. Records Management

Health Record Management Policy

16. Relevant Legislation

(Accessible via: Western Australian Legislation or ComLaw) sites)

- *Health Practitioner Regulation National Law Act 2010* (WA)
- *Mental Health Act 2014* (WA)
- Mental Health Regulations 2015
- *Occupational Safety and Health Act 1984* (WA)
- Occupational Safety and Health Regulations 1996
- *Medicines and Poisons Act 2014* (WA)
- Medicines and Poisons Regulations 2016

17. Relevant Standards

National Safety and Quality Health Service Standards
Comprehensive Care Standard: 5.29, 5.30, 5.33 and 5.34
Recognising and Responding to Acute Deterioration Standard: 8.3-8.5, 8.10, 8.12 and 8.13

WA Chief Psychiatrist's Standards for Clinical Care 2015

18. Related WACHS Resources and Learning and Development Programs

Clinical Risk Assessment and Management (CRAM) in Western Australian Mental Heath Services: Policy and Standards

WACHS Safety and Quality Comprehensive Care Standard intranet page

- Cognitive Impairment
- Self-harm and suicide
- Aggression and violence
- Seclusion and restraint

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Capabiliti LMS

- Aggression Prevention & Management Module 1 (MA1 EL2)*
- Delirium Modules (DELWA EL2)
- ETS HELP - Mental Health Assessment (ETS0027 EL1)

*Completion of this module is required for many staff in WACHS. Refer to the WACHS Workforce Learning and Development Policy – Learning Framework Structure (Appendix A).

19. Related WA health system Policies

MP010/18 Clinical Care of People With Mental Health Problems Who May Be At Risk of Becoming Violent or Aggressive Policy (and supporting information)

MP0095/18 Clinical Handover Policy

MP0122/19 Clinical Incident Management Policy

MP0086/18 Recognising and Responding to Acute Deterioration Policy

MP0053/17 WA Clinical Alert (Med Alert) Policy

OD0657/16 WA Health Consent to Treatment Policy

MP0051/17 WA Health Language Services Policy

20. Relevant WACHS documents

Alcohol, Tobacco and Other Drugs Clinical Practice Standard

Clinical Escalation of Acute Physiological Deterioration including Medical Emergency Response Policy

Cognitive Impairment Clinical Practice Standard

Documentation Clinical Practice Standard

Medication Administration Policy

Mental Health Care in Emergency Departments and General Wards Policy

Mental Health Restraint Policy

Mental Health Seclusion Policy

Procedural Sedation – Emergency Department Clinical Practice Standard

Residential Aged Care Services Policy

Restraint Minimisation Policy

Assessment and Management in the Emergency Department – Clinical Practice Standard

21. Policy Framework

Clinical Governance, Safety and Quality

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22. References

1. National Institute for Health and Care Excellence. Violence: the short-term management of disturbed/violent behaviour in mental health, health and community settings [Internet] May 2015 [Accessed: 11 September 2019]
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3. Royal Perth Bentley Group. Department of Emergency Medicine. Agitated and Violent Patient in the Emergency Department Standard Operational Procedure. May 2018 [Accessed 11 September 2019]
4. Western Australian Department of Health. Mental Health Division. Guidelines: the management of disturbed/violent behaviour in inpatient psychiatric settings. Perth: Department of Health; 2006 [Accessed 11 September 2019]
5. Hallett, N. Preventing and managing challenging behaviour [Internet] 2018Nursing Standard, vol. 32, no. 26, pp. 51 [Accessed: 11 September 2019]

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